

MDR Tracking Number: M5-04-1512-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 1-27-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the prescription medications Hydrocodone/Apap, Duragesic, Alprazolam, and Anexsia from 1/30/03 through 4/14/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 1/30/03 through 4/14/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22<sup>nd</sup> day of April 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division  
RLC/rlc

April 8, 2004

#### NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1512-01

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement.

This physician is board certified in orthopedic surgery. The \_\_\_ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, the \_\_\_ physician reviewer certified that the review was performed without bias for or against any party in this case.

#### Clinical History

This case concerns a 50 year-old female who sustained a work related injury on \_\_\_\_. The patient reported that while at work, she slipped and fell injuring her left hand, left shoulder and left knee. The patient underwent decompression of the left shoulder with repair of a tear of the supraspinatus and an acromioplasty as well as excision of the lateral end of the clavicle assisted with the arthroscope on 4/8/02. The patient also underwent knee surgery that included debridement of the joint involving the medial and lateral meniscus tears as well as a joint surface injury on 9/28/02. On July 31, 2002 the patient was prescribed an ACL brace and treated with Depo Medrol injection. A biofeedback intake note dated 6/24/03 indicated that the patient had undergone an MRI study that indicated degenerative disc disease at L5-S1, annular tears at L4-5 and L5-S1, disc bulge at L5-S1, and degenerative disc disease at C4-5. It also noted that the patient continued to complain of pain in her knee and swelling in the left ankle, as well as pain and stiffness in shoulder, both upper traps and tension type headaches, as well as headaches associated with her hypertension she had developed post injury. The patient has been treated with medications that have included hydrocodone/apap, duragesic patches, alprazolam, and anexsia.

#### Requested Services

Hydrocodone/Apap, duragesic, Alprazolam, anexsia from 1/30/03 through 4/14/03

#### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

#### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a 50 year-old female who sustained a work related injury to her left hand, shoulder and left knee on \_\_\_\_. The \_\_\_ physician reviewer indicated that although the patient had undergone left shoulder and left knee surgery due to the injury sustained on \_\_\_ the ancillary diagnosis in this case is spinal degenerative disease. The \_\_\_ physician reviewer also indicated that the spinal degenerative disease is the likely cause of this patient's pain and not the shoulder or knee. The \_\_\_ physician reviewer explained that the narcotic medications used to treat this patient's condition, are frequently used postoperatively, but not for a period longer than 6 weeks. The \_\_\_ physician reviewer also explained that this patient's post surgical pain from the work related injury would not necessitate medicine of this type greater than 3-6 months postoperatively. Therefore, the \_\_\_ physician consultant concluded that the Hydrocodone/Apap, duragesic, Alprazolam, anexsia from 1/30/03 through 4/14/03 were not medically necessary to treat this patient's condition.

Sincerely,